Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

May 13, 2010

TO: Senator Jack Hatch, Temporary Co-Chairperson of the MAPAC
Representative Lisa Heddens, Temporary Co-Chairperson of the MAPAC

FROM: Charlie Krogmeier, Director of DHS

RE: State Auditor's Report on the IowaCare Program

Attached are the Department's responses to the review of the IowaCare Program by the State Auditor's Office.

CJK/lm

Attachment

Finding A – Annual Certification

Recommendation: the General Assembly and DHS-IME should consider a modification to the Code to allow for a premium increase as is currently allowed for a premium decrease.

DHS Response: This is a policy decision that should be determined by the General Assembly. The original language did not address this option, we believe, because the program is designed to serve low-income Iowans. DHS will be more than happy to provide information regarding the potential impact if this is the direction the legislature would like to go.

Finding B – Database of IowaCare Enrollees

Recommendation: DHS-IME should review the criteria used to prepare the database to identify weaknesses which resulted in an incomplete database.

DHS Response: DHS is undertaking a review of existing data to address potential weaknesses. However, the ability to address may require additional funding.

Finding C – Eligibility Compliance

Recommendation: DHS-IME should implement procedures which ensure compliance with all eligibility requirements when approving IowaCare applications. In addition, case files should be complete and adequately documented.

DHS Response: DHS is currently defining new program integrity efforts for all of the eligibility programs including IowaCare. Efforts will include leveraging the use of data matches and increasing quality assurance reviews. The final plan will be completed by the end of June.

Finding D – Verification of Application Information

Recommendation: DHS-IME should consider verification of self-reported application information to improve the accuracy of application data and reduce the risk of IowaCare program approval for individuals who do not qualify for program services.

DHS Response: DHS is currently defining new program integrity efforts for all of the eligibility programs including IowaCare. Efforts will include leveraging the use of data matches and increasing quality assurance reviews. The final plan will be completed by the end of June.

Finding E – Provider Network and Benefits

Recommendation: The General Assembly and DHS-IME should evaluate the impact of the IowaCare Program on access to health care by qualified Iowans. In addition, the General Assembly and DHS-IME should review the benefit structure to determine if it is appropriate for the provider to have the ability to choose the level of services provided. Inconsistent application of benefits can create confusion for enrollees about which provider servicers are a covered benefit of IowaCare.

verified through an independent audit performed by the auditor each year. In fact, UIHC had to return funds to Medicaid in one year when the total Medicaid payments exceeded cost.

The only instance where a provider was paid in excess of cost was at one of the MHIs. When IowaCare was established, the financing and statute guaranteed the providers of a certain appropriation level. IME complied with that statute. MHIs are no longer part of the IowaCare provider network as their participation was phased out under the original federal terms and conditions.

Finding I – Progress Growth and Supplemental Payments

Recommendation: The General Assembly and DHS-IME should give careful consideration to the State's ability to maintain the IowaCare program if unrestricted enrollee growth continues.

DHS Response: DHS agrees. DHS has sought to carefully manage the program to ensure that funding is adequate. We note a waiting list has not been required. **We also note that the auditor's recommendations are contradictory. The state cannot both open the provider network and new services and at the same time keep program spending within budgetary constraints.**

Finding J – Physician Reimbursement

Recommendation: The General Assembly and DHS-IME should consider options available to address the financial burden placed on UIHC as a result of the lack of reimbursement for physician services.

DHS Response: The General Assembly acted this year to provide $14 million in reimbursement to the University for physician services.

Finding K – Quality Control

Recommendation: DHS should implement quality control procedures to determine on an ongoing basis if self-reported information is correct. In addition, DHS should monitor compliance with eligibility requirements and application processing to ensure case files are complete and accurate.

DHS Response: DHS is currently defining new program integrity efforts for all of the eligibility programs including IowaCare. Efforts will include leveraging the use of data matches and increasing quality assurance reviews. The final plan will be completed by the end of June.

Finding L – Insurance Cost Subsidy Program & Health Care Account Program

Recommendation: DHS-IME should reach a consensus for design of these programs and submit the results to the General Assembly.

DHS Response: The IME convened advisory groups on these projects as well as many others in 2006. The group met several times and included a number of stakeholders including representatives of the insurance industry. At that time, there was a lack of consensus on how to design such a program within the constraints of the Medicaid program.

Finding O – Cost and Quality Performance Evaluation

Recommendation: DHS-IME should annually contract with an independent consulting firm to compare the cost and quality of care provided by the medical assistance program and through the expansion population with the cost and quality of care available through private insurance and managed care organizations doing business in the state. In addition, DHS-IME officials should evaluate the improvements in cost and quality of care to the prior year.

DHS Response: We did not procure a vendor to do this specific task. We did research the idea and determined that it would be expensive and that the items specified above are already covered by other work the IME does, including:

- IowaCare Evaluation. The IowaCare program includes extensive evaluation of the program, approved by CMS, that reviews clinical data, utilization data, demographic data, provider perspectives, and as formal member surveys on their perspectives on the cost and quality of care. The evaluation compares IowaCare member's utilization and health care experiences with the regular Medicaid program. The evaluation is done by the University of Iowa Public Policy Center (UI PPC) who performs a number of other evaluations of the cost and quality of Medicaid services.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. IME contracts with UI PPC to perform CAHPS surveys in the regular Medicaid program and IowaCare. CAPHS is a standard tool used throughout the health care industry to measure quality and patient experience, so they provide a comparison of quality and cost across IowaCare and Medicaid, as well as private payors, such as Wellmark.

- Health Plan Employer Data and Information Set (HEDIS) measures – UI PPC also collects HEDIS measures in the regular Medicaid program. Like CAPHS, HEDIS is a standardized set of measures and methodologies for measuring health care quality indicators. Medicaid collects HEDIS measures for Medicaid Managed Care and Fee-for-Service programs to allow for comparison of quality. There are also national HEDIS measures on commercial plans that allow for comparison of Medicaid performance on key quality indicators.

- Medicaid Value Management – IME developed this program in 2007 to evaluate cost and quality in the Medicaid program in more targeted areas than HEDIS. A number of national health benchmarks are collected for Medicaid that can be compared to commercial plans. We use the measures to identify areas of over or underutilization or areas of quality concerns.

- IME performance – The performance of IME in operating the Medicaid program is reviewed each quarter through the collection of over 200 operational performance measures in the IME vendor contracts. In addition, IME contracted for a study of IME operations in comparison to commercial health plans operating best practices.

- Given all of these activities, we determined it would be duplicative to separately contract for a study of cost and quality. **The statute has now been amended to make this study permissive.**

to process correcting documents and carry forward any funds collected in the previous fiscal year to be spent in the subsequent fiscal year. On September 15, 2006, the Department made an entry on the State's Accounting System to carry forward unspent premiums collected in FY2006 to the subsequent fiscal year. The Department inadvertently coded the premium collections as federal revenues rather than as premium collections on the system. This entry was reviewed with all other entries processed that day per Department procedures; however, the incorrect revenue coding on the entry was not discovered.

During the same month, routine monthly Department reconciliations identified this error. The error was discovered after the 10th business day had passed so the State's Accounting System would not allow a correction to be processed. However, the premiums were tracked and appropriately classified in the Department's detailed ledgers. In the subsequent fiscal year, on September 15, 2007 when the Department made an entry on the State's Accounting system to carry forward unspent premiums collected in FY2007 to FY2008, the entry was processed correctly. The miscoding of these revenues on the accounting system had no impact on the timeliness of posting to the detail ledgers.

Premium collections, when received, are deposited into the trust fund. A portion of these premiums are considered state funds and a portion are considered federal funds. The federal portion is sent to CMS in the form of reductions to federal expenditures reported (which result in a reduction in federal funds drawn). In the beginning of the Iowa Care program, more premiums were collected than expenditures made, therefore the Department had a balance of federal funds on hand. Due to this excess, at no time during fiscal years 2006 – 2009 were federal revenues needing to be drawn. When the balance of federal funds was depleted, the Department began drawing routinely as expenditures occurred.